SEED HEALTH & WELLNESS
Tel: 1 (888) 973 - 3349
Fax: 1 (613) 825 - 4107
office@seedhw.com
www.seedhw.com

CIVILIAN: ☐ VETERAN: ☐ (K-number:_________________

Intake Form: Page 1 (Personal Information)

First Name:	Last Name:
Address:	City:
Province or Territory:	Postal Code:
Home Phone Number:	Cell Number:
Shipping address different: Yes: ☐ No: ☐	Alternate Shipping Address (if necessary):
E-Mail:	Health Card Number and Expiry Date:
Emergency / Caregiver Contact Name, Relationship:	Emergency / Caregiver Contact Phone Number:
I Authorise my designated Emergency contact to speak on my behalf to my registered Licence producer: Yes: ☐ No: ☐	Initials: ___________
Date of Birth:	Gender: M____F_____O_____

Medical Information:

Allergies to Medications:	Reaction:
Primary Care Physician:	Phone Number:
Specialist Name:	Phone Number:
Insurance Carrier:	Policy Number:

Please select yes or no if you give consent to Seed Health & Wellness to update your Physician and Specialist on the progress of your Cannabinoid Therapy? YES _____ NO _____

Do you give consent to Seed to send updates via your e-mail? YES ______ NO______

How did you hear about Seed Health & Wellness?

I understand that any Physician I see through Seed will not replace my Primary Care Physician or Specialist.

Signature:______________________________ **Date:**__________________

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Intake Form: Page 2 (Medical History)

Main reason(s) for accessing Cannabinoid Therapy?

Please check all that apply that you wish to have improved with Cannabinoid Therapy:

☐ Reduce Pain________________________ ☐ Improve Daily Functions ________________________
☐ Improve Sleeping Habits________________________ ☐ Improve Appetite ________________________
☐ Improve Daily Activities______________________ ☐ Improve Mood ________________________
☐ Other____

Current/Past Health Problems:

____
____
____
____

Family Medical History (Parents and Siblings):

____

Current and Past Treatments: (Select Yes of No if it was effective)

Current Treatments:	Past Treatments:
1)_________________________________Yes______ No	1)_________________________________Yes______ No
2)_________________________________Yes______ No	2)_________________________________Yes______ No
3)_________________________________Yes__ No___	3)_________________________________Yes__ No___
4)_________________________________Yes__ No___	4)_________________________________Yes__ No___

Please list all Medications including over the counter:

____
____

Please explain physical limitations and how it affects your daily routine:

____
____

Please list past or upcoming surgeries:

____
____

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Intake Form: Page 3

Have you been diagnosed with a Mental Health Condition? Yes____No______Please explain if yes.

____

Last time you had an episode? Day____Month_____Year______Were you committed? Yes______No_______
If you were committed, please explain:____

____

Please describe your alcohol consumption:_______X Day______X Week ______
Please describe your tobacco consumption:______X Day______X Week ______

Do you use any illicit drugs? Yes____No_____Have you had a substance abuse problem? Yes______No_____
If Yes to either, please explain with date of last use and what type of program you used for help.

____

Personal Cannabis Use

Are you currently using Cannabis? Yes______No______If no, please skip to signature box below.

How many grams per day are you consuming? ____

How have you been consuming your Cannabis? Please select the best answers from the list below:

☐ Smoking ☐ Sublingual Oils ☐ Topicals ☐ Vaporizing ☐ Edibles ☐ Tinctures

How are you currently using your Cannabis? Please describe your daily routine with amounts. Example: Vape in the morning, edibles throughout the day.

____
____
____

Have you been legally authorized to use/possess Cannabis previously? Yes____No_____

If Yes, how many grams a day were you authorized to use?______Grams per day.

Have you experienced any negative side effects from consuming Cannabis? Yes____No_____
If Yes, please explain:____

____

Are you interested in participating in future studies? Yes______No______

Signature:__________________________ **Name:**_____________________ **Date Signed:**_____________________

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PHQ-9 Over the last 2 weeks, how often have you been bothered by any of the following problems? Select the most appropriate number for each.		Not at all	Several Days	More than half the day	Nearly Every Day
1	Little interest or pleasure in doing things.	0	1	2	3
2	Feeling down, depressed, or hopeless.	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4	Feeling tired or having little energy.	0	1	2	3
5	Poor appetite or overeating.	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let your family down.	0	1	2	3
7	Trouble concentrating on things such as reading the newspaper or watching television.	0	1	2	3
8	Moving or speaking slowly that the other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9	Thoughts that you would be better off dead or hurting yourself in some way.	0	1	2	3
		PHQ Total Score:			

GAD-7 Over the past 2 weeks, how often have you been bothered by any of the following problems? Select the most appropriate number for each.					
1	Feeling nervous, anxious, or on edge?	0	1	2	3
2	Not being able to stop or control worrying.	0	1	2	3
3	Worrying too much about different things.	0	1	2	3
4	Trouble relaxing.	0	1	2	3
5	Being so restless that it's hard to sit still.	0	1	2	3
6	Becoming easily annoyed or irritable.	0	1	2	3
7	Feeling afraid.	0	1	2	3

GAD Total Score:

Developed by Drs. Robert L Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Phizer Inc. No permission required to reproduce, translate, display or distribute.

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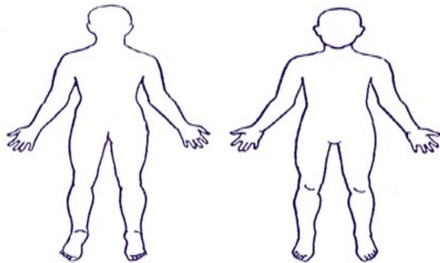
Brief Pain Inventory & Assessment

1) On the diagram, select the areas where you feel pain.



2) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today? YES NO

3) Please rate your pain by selecting one number that best describes your pain at its worst in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

4) Please rate your pain by selecting the one number that best describes your pain at its least in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

5) Please rate your pain by selecting the one number that best describes your pain on average.

0 1 2 3 4 5 6 7 8 9 10

6) Please rate your pain by selecting the one number that tells how much pain you have right now.
0 1 2 3 4 5 6 7 8 9 10

7) What treatments or medications are you receiving for your pain?
____
____

8) In the past 24 hours, how much relief have pain treatments Or medications provided? Please select the percentage That the most shows how much relief you have received.
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

9) Select the one number that describes how, during the past 24 hours , pain has interfered with your:

A: General Activity
0 1 2 3 4 5 6 7 8 9 10

B: Mood
0 1 2 3 4 5 6 7 8 9 10

C: Walking Ability
0 1 2 3 4 5 6 7 8 9 10

D: Normal work (includes both work outside the home and housework)
0 1 2 3 4 5 6 7 8 9 10

E: Relations with other people
0 1 2 3 4 5 6 7 8 9 10

F: Sleep
0 1 2 3 4 5 6 7 8 9 10

G: Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10

H: Ability to concentrate
0 1 2 3 4 5 6 7 8 9 10

I: Appetite
0 1 2 3 4 5 6 7 8 9 10

May be duplicated for use in clinical practice. As appears in McCaffery M, Pasero C: Pain: Clinical manual, p. 61, 1999, Mosby, Inc. From Pain Research Group, Department of Neurology, University of Wisconsin-Madison. The material provided by North Dakota Health Care Review, Inc., Minot, ND, 701-852-4231, under contract #500-99-ND03 with the Centers for Medicare and Medicaid Services (CMS). The contents presented do not necessarily reflect CMS policy. August 2001.

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Adult Version: These questions refer to the past 12 months. Select your response.			
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs?	Yes	No
5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Have you had blackouts or flashbacks as a result of drug use?	Yes	No
7.	Do you ever feel bad or guilty about your drug use?	Yes	No
8.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9.	Has drug abuse created problems between you and your spouse or parents?	Yes	No
10.	Have you lost friends because of your drug use?	Yes	No
11.	Have you neglected your family because of your drug use?	Yes	No
12.	Have you been in trouble at work (or school) because of drug use?	Yes	No
13.	Have you lost your job because of drug abuse?	Yes	No
14.	Have you gotten into fights when under the influence of drugs?	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16.	Have you been arrested for possession of illegal drugs?	Yes	No
17.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19.	Have you gone to anyone for help for a drug problem?	Yes	No
20.	Have you been involved in a treatment program specifically related to drug use?	Yes	No

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Opioid Risk Tool Clinician Form

(Includes point values to determine scoring total)

	Female	Male
1. Family History of Substance Abuse:		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription Drugs	☐ 4	☐ 4
2. Personal History of Substance Abuse:		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription Drugs	☐ 5	☐ 5
3. Age (mark box if between 16-45):	☐ 1	☐ 1
4. History of Preadolescent Sexual Abuse:	☐ 3	☐ 0
5. Psychological Disease:		
Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals:	______	______

Total Score Risk Category:

Low Risk: 1-3 Moderate Risk: 4-7 High Risk: 8+

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction. Webster LR, Webster R. Predicting aberrant behaviors in opioid –treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005; 6 (6): 432

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Cardiology Questionnaire

Have you ever experienced any of the following potential heart symptoms? Please check boxes if you have.

Potential Rhythm Abnormality

☐ Dizziness ☐ Light-Headedness ☐ Palpitations ☐ Anxious Feeling ☐ Fainting

☐ Premature Heartbeats ☐ Shortness of Breath ☐ Nausea/ Indigestion ☐ Numbness

Have you ever experienced any of the following pain symptoms?

Pain and Other Symptoms

☐ Sudden discomfort that does not go away with rest

☐ Pain that may feel like burning, squeezing, heaviness, tightness or pressure

☐ Pain that may be in the chest, neck, jaw, shoulder, arm, and or back

☐ Chest pain or discomfort that is brought on with exertion and goes with rest

☐ Increased or irregular heart rate, palpitations

☐ Irregular sweating

☐ Cool, clammy skin

☐ Unusual fear or anxiety

Cardiovascular Risk Factors

☐ High Blood Pressure ☐ History of Smoking ☐ Diabetes ☐ High Cholesterol

☐ Overweight ☐ Stress ☐ Anxiety ☐ Depression

Family History

☐ Diabetes ☐ High Cholesterol ☐ Stroke ☐ High Blood Pressure

☐ Cardiovascular (i.e. arterial disease, heart attack) ☐ Mental Illness

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Release, Acknowledgement & Indemnity Form

I_____________________understand that this release, acknowledgement & indemnity form contains important information about medical cannabis. I also understand that the assessing physician requires that I acknowledge and understand the information before he/she may issue a prescription and/or authorization for the use of medical cannabis.

I further understand that the consulting physician will not be assuming care for me. He/she will, however, assess and evaluate the appropriateness of my request to use medical cannabis to assist in treating the medical conditions and associated symptoms that I believe, from my own personal experience, to be helpful treating said medical conditions.

I confirm that the assessing physician will be my medical practitioner for the sole purpose of obtaining a medical cannabis authorization and/or prescriptions.

INITIAL__________

I agree not to make any claim or complaint or commence any legal proceedings against Seed Health & Wellness, the assessing physician, his/her practice, my family physician or any other involved physicians (such as Specialists) in relation to:

- My use of cannabis as a medicine; and
- My application or prescription for possessing, obtaining and using medical cannabis

INITIAL__________

I am aware that physicians generally agree that medical cannabis may:

- Distort perception (sound, sight, touch, time)
- Impair learning and memory
- Problem solving and thinking
- Increase heart rate and reduce blood pressure
- Produce fear, anxiety, panic and distrust
- Impair coordination (Due to individual reaction to CBD and THC, avoid driving for 6-8 hours after consumption of medical cannabis (CBD, THC).

I am aware that ingesting a high dose of medical cannabis may cause nausea and disorientation.

I agree to only purchase my medical cannabis from a Licensed Producer. I understand that possession of cannabis from any other sources is illegal.

INITIAL__________

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Release, Acknowledgement & Indemnity Form

I acknowledge and am aware that there is considerable debate and a great lack of consensus among physicians about;

- the appropriate use of medical cannabis
- the appropriate dosage of medical cannabis
- the risks of smoking medical cannabis as compared to vaporizing or ingesting
- the risks of smoking whole plant medical cannabis as compared to extracting the medicinally active cannabinoids and medicating the same
- the long term health and psychological risks associated with the use of medical cannabis
- the degree to which regular consumption of medical cannabis;
    - may contribute to pulmonary infections and respiratory cancer
    - may damage cells in the bronchial passages which protect the body against inhaled microorganisms and decrease the ability to the immune cells in the lungs to fight off fungi, bacteria, and tumor cells. For patients with already weakened immune systems, this means an increase in the possibility of dangerous pulmonary infections, including pneumonia.
    - May weaken various natural immune mechanisms, including but not limited to macrophages and T-cells.
    - in some cases, it may exacerbate mental illness, including but not limited to bipolar disorder and schizophrenia.

INITIAL___________

I am further aware that the above listed medical concerns are further compounded by the lack of consistency and uniformity in available medical cannabis products. With conventional drug products, I generally consume a medication of precisely known molecular quantity. I recognize that the full raw plant of medical cannabis does not work this way. I understand that I will get varying compositions of different cannabinoids and varying proportions of different cannabinoids from strain to strain and even, to a lesser degree, from plant to plant of the same strain.

I am further understand that there is significant uncertainty regarding the consistency of the medical cannabis drug product I may medicate with which further compounds the practical issue of medicating with an inconsistent drug such as medical marijuana.

In seeking medical cannabis treatment (Cannabinoid Therapy) I confirm I have consulted with a physician and have discussed alternative and conventional treatment options for my condition.

INITIAL___________

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Release, Acknowledgement & Indemnity Form

I agree to receive an authorization for medical cannabis and not to consume more medical cannabis than what is on my authorization from the assessing physician. I agree to the safe storage of my medical cannabis, away from all others including children, and to be kept in a locked child proof container. I acknowledge that ingesting cannabis during pregnancy and breastfeeding is not advisable. I agree to inform the assessing physician if I am pregnant, planning on becoming pregnant, or breastfeeding.

INITIAL__________

Despite these medical concerns, debates and practical issues, I honestly believe that for the treatment of my medical condition(s) and symptom(s) the benefits of medical cannabis outweigh the risks. This is my decisions and I do not support any claims made by my family, friends or other interested parties against Seed Health & Wellness or associated physicians.

I hereby release Seed Health & Wellness, my assessing physician, his/her clinic, my family physician, and any other involved physicians or specialists from any and all actions, claims, causes of actions, complaints (even from my family and friends) and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence to my use of medical cannabis and my application to possess medical cannabis. This release from liability is to be binding on heirs, executors and assigners. I consent to the disclosure, sharing and use of my personal information and medical records by the assessing physician and my licensed producer. I understand that this information may be used to contact, assess and register my medical cannabis use for analysis and research to better help our patients.

INITIAL________

I acknowledge that while the assessing physician may issue a declaration that I stand to potentially benefit from medical cannabis, the physician will not serve as my primary care physician. As such, I agree to seek regular medical care from my primary care physician and that the assessing physician will only authorize his/her support for my medical cannabis use. I also consent to the assessing physician notifying any specialists that I have seen of my decision to use medical cannabis and I accept any consequences of such notification.

In situations where Tele-medicine is used to conduct consultations and follow-up appointments, I agree that it is an appropriate method for my circumstances, and understand that I will be communicating potentially sensitive personal health information electronically. Further, I understand to inform the physician if the location for the appointment doesn't provide adequate privacy to protect my personal health information, and will take appropriate measures to secure my own privacy in the case of Tele-medicine appointments. I am aware that technological errors or physician scheduling errors can occur, resulting in the rescheduling of my appointment.

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I acknowledge that despite the reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information. I agree to inform the physician of any types of information you do not wish to share electronically. I understand that Seed Health & Wellness, or the physician, are not responsible for information loss due to technical failures associated with my software, hardware, or internet service provider.

I agree to notify my primary care physician myself about my intent to use medicinal cannabis as cannabis may interact with other medications I am currently, or will be on in the future. If licenses, I agree not to resell or give away any of my medication (medicinal cannabis). I agree to check with the local bylaws in my area in regards to cannabis, and or smoking and vaporizing. I also agree that any legal actions will take place in Ontario and be governed by the laws of Ontario, Canada.

I agree to treat my medical cannabis authorization as I would any prescription medication. I acknowledge that I will keep my medical cannabis up and out of reach of children, in a locked and secure child proof container.

Violation of any of the terms of this contract may result in the termination of my authorization of medical cannabis.

Name ____________________________________

Signature _________________________________

Date (M/D/Y) ______________________________

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CAREGIVER FORM

To be completed by the patient and the caregiver responsible for the patient.

Caregiver Information

Male ☐ Female ☐ Other ☐

Caregiver's First Name:	Caregiver's Last Name:	Caregiver's D.O.B. (M/D/Y):
Primary Phone Number:	E-Mail:	May we leave a voicemail? ☐ YES ☐ NO

Signature

I,_______________________________, (Caregiver's Name) am the responsible caregiver for the client/patient named_____________________________(Client/Patients Name) and the relationship to the client is _____________________________________.

By signing this caregiver form:

1. You consent to the Licensed Producer's collection, use and disclosure of the personal information contained in it, in accordance with the License Producers External Privacy Policy available at the License Producers website. This includes, without limitation, disclosure of any and all patient personal information collected by the License Producer to the patient's caregiver and disclosure of any and all caregiver personal information to the patient. Hard copies of the External Privacy Policy are available upon request. If the personal information in the Caregiver Form pertains to someone other than you, you represent and warrant that you have obtained their consent and/or have authority to consent on their behalf. Consent may be withdrawn at any time but such withdrawal will not have retroactive effect. NOTE: This may have implications to you and/or the subject individual and will not affect the collection, use and disclosure of personal information where such collection, use and discloser is permitted or required by law without consent.

2. As the patient, you authorize the responsible individual/caregiver to act on your behalf with respect to anything you could do on your behalf with the License Producer and you authorize the License Producer to accept such authority.

Patient Signature:___________________Caregiver Signature:______________________Date:___/___/___